CHAPTER VI

UTILIZATION REVIEW AND CONTROL

MANUAL TITLE: HOME HEALTH MANUAL

CHAPTER 6, UTILIZATION REVIEW AND CONTROL REVISION DATE: 7/5/2023

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations (CFR), Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review will not be considered reimbursable, and is subject to retraction.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the BHSA or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction

an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: recipientfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Recipient Audit Unit
600 East Broad Street
Richmond, Virginia 23219

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS. More information about the PUMS process is located in Chapter IV of this provider manual.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall fully disclose the extent of services provided in order to support provider’s claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.

- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.
- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.
- Evidence that for members receiving substance use case management, the ARTS service provider collaborated with the substance use case manager and provided notification of the provision of services with appropriate consent meeting requirements of 42 CFR Part 2. In addition, the provider must send written monthly updates to the substance use case manager. The individual's Primary Care Provider (PCP) must be notified of services to ensure coordination of care. A written discharge summary must be sent to the PCP and substance use case manager within 30 days of the service discontinuation date. Only one type of case management can be provided at a time.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than five years after the date of service or discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain

adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 482.24 for additional requirements.

The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

HOME HEALTH PROGRAM

The Home Health agency and its staff must operate and furnish services in compliance with all applicable federal, State, and local laws and regulations and must comply with accepted professional standards and principles that apply to professionals furnishing services. All personnel furnishing services must maintain liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences must establish that effective interchange, reporting, and coordination of patient care has occurred. A written summary report for each participant must be sent to the attending practitioner at least every 60 days.

DOCUMENTATION REQUIREMENTS FOR HOME HEALTH SERVICES

Face-to-Face Encounters for Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of Home Health services (as defined in 12VAC30-50-160) unless a face-to-face encounter has been performed by an approved practitioner (see Chapter 4) within 90 days prior to when the individual begins Home Health services or within 30 days after the individual begins Home Health services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Home Health services.

Providers **may** use the **sample form** (found below) to document these new requirements. If a provider does not use the DMAS sample form or the CMS-485 (with the F2F elements clearly included) to document the F2F encounter, any supporting documentation must be clearly titled and easily recognizable as documentation of the F2F encounter and include the required elements listed below.

Providers who opt to use their own forms or systems to document the F2F encounter must include the following required elements:

1. The date of the face-to-face encounter;
2. The practitioner, including full name and credentials, who conducted the face-to- face encounter;
3. The primary reason the Medicaid individual requires Home Health services;
4. Any communication between the ordering practitioner and the practitioner who conducted the face-to-face encounter, if such individuals are different;
5. The date of the order and the ordering practitioner's full name and signature.

SAMPLE FORM: Home Health Face-To-Face Encounter Form

Individual Name:_____ Date of Birth:_____ Medicaid ID:

Check one of the following:

[ ] Same Practitioner: Face to Face Visit: I had a face-to-face encounter that meets the practitioner face-to-face encounter requirements with the individual. The individual is under my care. I have initiated the establishment of the plan of care.

OR

[ ] Different Practitioner: Face to Face Visit: A face-to-face encounter was performed on this patient by (check one):

- A practitioner licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist working in collaboration and with a practice agreement with the practitioner who orders the individual's services;
- A certified nurse midwife ;
- A licensed practitioner assistant working under the supervision of the practitioner who orders the individual's services; or
- For individuals admitted to Home Health immediately after an acute or post-acute stay, the attending acute or post- acute practitioner.

Date of Face-to-Face Encounter:_____

Based on the clinical finding of this encounter, the following services are medically necessary.

□ Skilled Nursing □ Therapy (type_____) □ Home Health Aide

Based on clinical findings of this encounter, the services this individual needs are the following:

□ Teaching/Training (Disease Management) □ Observe/assess □ Anticoagulation therapy

□ Bladder Cath Care □ Wound care □ Tracheostomy/Ventilator care

□ Medication/Education management □ IV Care □ Ostomy Care (Bowel/Bladder)

☐ Nutritional Status/Tube feedings ☐ Decubitus Care ☐ Chest Tube

☐ Equipment assessment/training ☐ Oxygen therapy (new/changed)

☐ Other: _____

Ordering Practitioner Signature:_____ Date:

_____

_____

Ordering Practitioner Printed Name:_____

_____

_____

Face-to-Face Practitioner Signature (if applicable):_____

_____

Face-to-Face Practitioner Printed Name (if applicable):_____

_____

_____

Note to Ordering Practitioner: Please place a copy of this Face-to-Face form in the individual's medical record.

Electronic Visit Verification (EVV)

1. *Providers shall select and obtain an EVV system that captures the EVV elements in an electronic process.*
2. *The following EVV data elements are required to meeting EVV compliance for Home Health Services:*
    a. *Type of service(s) performed (revenue code);*
    b. *Individual receiving the service;*
    c. *Date of the service;*
    d. *Location of the service delivery (can be either in an individual's home or community setting);*
    e. *The worker providing the service (each worker should have a unique identifier)*
    f. *The time the service begins and ends.*

3. *The EVV provider shall: 1.) Ensure daily back-up for all data collected; 2.) Protect data securely and reliably; 3.) Demonstrate a disaster recovery mechanism allowing for use within twelve hours of disruption to services (subject to exceptional circumstances such as war and other disasters of national scope); and 4.) Be capable of producing reports of all services and supports rendered, the individual's identity, the start and end time of the provision of services and supports and the date/s of service in summary fashion that constitute documentation of service that is fully compliant with regulation.*

GENERAL DOCUMENTATION REQUIREMENTS

The documentation of Home Health services shall, at a minimum:

a) Describe the clinical signs and symptoms of the participant's illness;
b) Document an accurate and complete chronological picture of the participant's clinical course and treatments;
c) Document all treatment rendered to the participant in accordance with the plan with specific attention to the frequency, duration, modality, response, and identify who provided the care (include the full name, title and date);
d) Document the changes in the participant's condition;
e) Include all plans of care;
f) Document drugs and treatments as ordered by the practitioner;
g) Document that the Home Health agency staff is checking all medicines a participant is taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and must promptly report any problems to the practitioner; and
h) Describe the efforts to discharge the participant from Home Health services
i) Documentation describing the efforts to provide the service and contacts to the practitioner must be maintained in the medical record.

NOTE: Home Health agencies must follow all Virginia Department of Health Professions' guidelines on qualifications and supervision of staff as specified in 12 VAC5-381.

When an individual is admitted to Home Health services, a start of care assessment must be completed no later than five (5) calendar days after the start of care. If services cannot be provided as ordered by the practitioner (e.g., in the case of the unavailability of a service, staff absences, etc.), the attending practitioner must be notified and the medical record must reflect the attempts made by the Home Health agency to provide the service and reasons why the service could not be provided as ordered. Documentation describing the efforts to provide the service and contacts to the practitioner must be maintained in the medical record.

If corrections are required, the error shall be crossed out, corrected, initialed and dated by the person who made the corrections.

Practitioner Documentation Requirements

Participants of Home Health services must be under the care of a practitioner, which is defined as a physician, nurse practitioner, clinical nurse specialist and physician assistant, who is legally authorized to practice and act within the scope of his or her license. The practitioner may be the participant's private physician, nurse practitioner, clinical nurse specialist or physician assistant, a practitioner on the staff of the Home Health agency, practitioner working under an arrangement with the assisted living facility (ALF) which is the participant's residence or, if the agency is hospital-based, a physician on the hospital staff.

Participants are accepted for treatment on the basis of a reasonable expectation that the participant's medical and nursing needs can be met adequately by the Home Health agency in the participant's place of residence. Care follows a written plan of care established and reviewed by a practitioner as often as the participant's condition requires, but at least every 60 days. Services must be necessary to carry out the plan of care and must be related to the participant's medical condition.

The plan of care, developed in consultation with the appropriate qualified agency staff, must include the following applicable documentation:

- Diagnosis and prognosis;
- Functional limitations;
- Activities permitted;
- Mental status;
- Safety measures to protect against injury;
- Orders for medications and treatments;
- Orders for dietary or nutritional needs;
- Orders for nursing and therapeutic services;
- Orders for Home Health aide services;
- Orders for medical tests, including laboratory tests and x-rays;
- Measurable goals for treatment for all disciplines within established time frames;
- Frequency and duration of all services;
- Rehabilitation potential; and
- Instructions for a timely discharge or referral.

A written practitioner's statement, which may be in the form of the practitioner's orders on the Home Health certification plan of care, located in the medical record must certify that:

- The participant needs nursing care on an intermittent basis; the participant needs physical or occupational therapy or speech-language pathology services; and

- A plan for furnishing such services to the participant has been established and is periodically reviewed by a physician.

The practitioner is responsible for signing (name and title) and dating (month, day, and year) this required documentation. Any dictated typed reports must be signed and dated by the practitioner. A required practitioner signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the practitioner. However, these methods do not preclude other signature requirements that are not for Medicaid purposes. If the practitioner chooses to use a rubber stamp on documentation requiring his or her signature, the practitioner whose signature the stamp represents must provide the Home Health agency administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The practitioner must initial and completely date all rubber-stamped signatures.

The initial plan of care (certification) must be reviewed by the attending practitioner or practitioner designee. The practitioner must sign the initial certification before the Home Health provider may bill DMAS. A practitioner shall review and recertify the plan of care every 60 days. DMAS will not reimburse the Home Health agency for services provided prior to the date of the practitioner's signature.

A practitioner recertification shall be performed within the last five days of each current 60-day certification period, i.e. between and including days 56-60. The practitioner recertification statement must indicate the continuing need for services.. The practitioner must sign the recertification before the Home Health provider may bill DMAS.

The recertification plan of care must include any orders obtained as a result of modifications to the previous plan of care, which remain in effect, and include updated goals and time frames for goal achievement for all services ordered. The practitioner must approve, in writing, modifications to the plan of care. DMAS will not reimburse the Home Health agency for services prior to the date of the practitioner's signature.

A verbal order that necessitates a change in the current plan of care must be signed and dated by the practitioner. The verbal order must be received by a registered nurse or qualified therapist. If rehabilitative therapies are the only services ordered by the practitioner, a qualified licensed therapist may receive the verbal order.

Nursing Documentation Requirements

The following components are required for nursing documentation:

Nursing Assessment - A start of care assessment must be made by a registered nurse at the time of admission to Home Health nursing services. This initial evaluation must be maintained in the participant record throughout the duration of treatment and must contain a history of the medical conditions; a review of the physical systems and the identification of the physical problems and disabilities; and a psycho-social assessment which must include the identification of support persons, environmental issues, needs and the reason for admission to Home Health services.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all participants and must indicate the actual or potential participant/family needs, measurable goals and objectives, specifically state the method by which they are to be accomplished, and include time frames for goal achievement. Nursing care plans must

be updated as the participant's nursing care needs change. If Home Health aides are needed to provide services, the nursing care plan should reflect their duties and frequency. If the nursing care plan is a part of the Home Health certification plan of care, all of the above documentation must be identified.

Nursing Visit Notes - Visit notes are required at the time of each visit and must describe the treatment and/or instruction provided. In addition, the notes must address the medical status, treatment and/or instructions given for any special nursing procedures and identification and resolution of acute episodes. Treatment and care must be in accordance with the provisions of the plan of care.

Comprehensive Nursing Visit Documentation Requirements

Reimbursement at the comprehensive rate is based on the complexity of the skilled nursing procedures ordered and performed during each visit and not on the complexity of the overall case. A visit to determine if the patient and/or caregiver performed a procedure as previously taught would not be considered reimbursable at the comprehensive visit rate. An example of this type of visit would be the assessment by the nurse that the patient or caregiver had already performed a procedure correctly, prior to the nurse's visit, and no further complex teaching/treatment was required or medically necessary by the nurse.

The following examples identify some situations and describe the minimum documentation requirements necessary to support the appropriateness of billing at the comprehensive visit rate. These examples and participant cases must be within the context of the definition of comprehensive visits. Many participants and caregivers learn from short, focused teaching sessions. These short, focused sessions do not qualify for reimbursement at the comprehensive rate.

Diabetic Instruction

- Documentation must show that the assessment, direct care, or teaching requires an extensive length of time and that the participant and/or caregiver are able to comprehend in-depth instruction. Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.
- The teaching plan must be clearly outlined.
- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Wound Care

- The participant must have multiple or extensive wounds.
- Treatment orders must include multi-step procedures requiring longer

periods of time than routine wound care.

- All documentation as to the size, depth, appearance, color, odor, drainage, and treatment provided must be included in each visit note.
- Arrival and departure times must support the extended duration of the visit for the purpose of teaching the participant or caregiver and the complexity of the skilled procedures performed.
- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.

Intravenous (I.V.) Infusion

- Documentation must include arrival and departure times, supporting an extended duration of the visit for the purpose of teaching a participant or caregiver to administer I.V. fluids or medications and the complexity of the procedures performed.
- Visit notes must outline all instructions given and the ability of the participant or caregiver to demonstrate and/or verbalize comprehension in carrying out the care plan.
- If the nurse is required to stay with the participant throughout the administration of an I.V. medication, the practitioner orders and visit notes must identify the participant-specific risk factors requiring the continuous monitoring by the nurse. Additionally, the specific requirements for monitoring, reporting, and skilled interventions must be detailed in the practitioner's orders and documented in each visit note.

NOTE: Routine I.V. administration of fluids for hydration or medication which have no identified significant risk factors requiring nurse monitoring are not considered high-tech even if the task takes eight hours. DMAS does not consider a charge for a second skilled visit the same day as reasonable and necessary when the visit is for the sole purpose of discontinuing an I.V. when there is no other skilled intervention required.

Instruction to Non-English Speaking Participants or Caregivers

- Circumstances must be documented regarding the fact that the only acceptable communication is in the participant's birth language (no interpreter, no staff member who speaks the language of the participant or caregiver, no English speaking family members, friend, or other support); and
- Documentation must include to the duration of the visit (arrival and departure times) and the type of service rendered to support the complexity of the procedures performed and/or the instructions given to

the participant and/or caregiver.

NOTE: These situations should be very rare. Once a means of communication has been established, reimbursement at the comprehensive visit rate will no longer be considered necessary.

Extended Time Due to the Age/Condition of the Participant

- Documentation must describe the condition, the skilled procedure performed, and the difficulty resulting from the particular set of problems in situations (i.e. attempting to start peripheral I.V.s on a child with spasticity or an adult with fragile veins.
- Visit notes must identify arrival and departure times and include a clear description of the efforts to complete the practitioner ordered skilled procedure and why these efforts were unsuccessful.
- Visit notes must also document what steps the nurse took to either obtain additional orders or have another skilled professional attempt the procedure.

NOTE: If another nurse were successful in the performance of the skilled procedure, this visit would not be considered reimbursable at the comprehensive visit rate by Medicaid.

Visits that require additional nursing time because of social issues do not constitute reimbursement at the comprehensive nursing visit rate. Examples may include, but are not limited to:

- The participant has no community support for meals, transportation, etc.;
- The participant lives alone and has no family support; or
- The housing conditions are inappropriate or unsafe.

All nursing documentation must be fully signed with full name, title and dated completely with month, day and year.

Rehabilitative Therapies Documentation Requirements

If physical therapy, occupational therapy, or speech-language pathology services are ordered by the practitioner and rendered to a Home Health participant, there must be an initial assessment conducted by a qualified therapist. The initial assessment must include current functional deficits, clinical status, symptoms of the participant's condition, including the diagnosis, and identification of needs indicating rationale for therapeutic interventions, prior to the delivery of Home Health therapy services. The initial assessment must also document an accurate and complete chronological picture of any clinical course of other therapy treatments, including any prior Home Health or rehabilitation treatments. A plan of care specifically designed for the participant must be established and must include measurable short and long-term goals which describe the

anticipated level of functional improvement and include time frames for improvement and/or goal achievement. This plan must be reviewed and updated as needed, but at least every 60 days. This includes updating goals and achievement dates that are identified on the care plan. When all the established long-term goals have been met based on the achievement dates and there are no other established long-term goals identified on the plan of care, the therapist must reevaluate the plan of care to determine if it is appropriate for services to continue. If there are no other long-term goals to be established, the participant should be discharged from services.

Progress notes must be written in the participant's medical record at the time of each visit to a Home Health participant and must include the type and duration of the treatment given, the participant's response to the treatment, and progress or lack of progress toward established goals. All entries to the medical record must be signed and fully dated by the provider of treatment, including full name and title. Treatment and care must be provided in accordance with the plan of care. The progress note must also indicate any education conducted, the participant/caregiver's ability to carry out the instructions given and any home program established. None of the above services are reimbursed by DMAS without a current practitioner's order which specifies the service treatment plan, the frequency and duration of the provision of the service.

If the participant is receiving therapy services from more than one provider (e.g., Home Health and outpatient or school rehabilitation), the participant's medical record must show documentation of coordination of these services, including goals, time frames for goal accomplishment and progress or lack of progress towards the established goals coordination efforts.

Home Health Aide Documentation Requirements

Written instructions for Home Health aide services must be documented in the medical record prior to the provision of services. These instructions must clearly identify all the services the aide is expected to perform for the participant in the place of residence. These instructions must be completely signed and dated by the registered nurse or licensed qualified therapist.

Home Health aide visits must be documented in the participant's medical record for each visit to the participant in his/her place of residence must include identification of the services provided by the Home Health aide and must be signed and fully dated with the month, day and year, by the aide who performs the services. Documentation must also reflect that the services are being provided in accordance with the Home Health plan of care. Home Health aide documentation should also include any information that identifies why the participant or Home Health aide is unable to participate in meeting the goals of Home Health aide services.

Supervision of Home Health Aide Services

Based on the Virginia Administrative Code, Home Health aide services must be provided under the general supervision of a registered nurse.. This documentation may be in the form of a visit note, by the registered nurse for the purpose of the supervisory visit of the

Home Health aide only and must be signed and fully dated with the month, day and year. The results of the supervisory visit must be documented (e.g., if the Home Health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver). If the supervisory visit is conducted in conjunction with the skilled visit, the documentation must reflect that the supervisory task was performed and the results (i.e., if the Home Health aide is performing services in accordance with the plan of care and the response of the participant and/or caregiver.)

When only Home Health aide services are provided, a registered nurse must make a supervisory visit to the participant's residence at least once every 60 days. Supervisory visits should occur while the aide is providing care.. The supervisory visit is not reimbursable Medicaid.

When skilled nursing services, in addition to Home Health aide services, a registered nurse must make a supervisory visit to the participant's place of residence at least every two weeks (either when the aide is present or absent). Supervisory visits should not be made when the aid is absent. This supervisory only visit is not reimbursable Medicaid.

When rehabilitative therapy (physical, occupational and/or speech-language pathology therapies, in addition to the Home Health aide) are the only services provided, a licensed qualified therapist may make the supervisory visit instead of the registered nurse.

Discharge Planning

Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to Home Health services. Discharge planning documentation for all disciplines providing services to the participant must include any or all of the following:

- Anticipated improvements in limitations or health care needs;
- Time frames necessary to meet the goals;
- Feasibility of alternative care, including options for other Medicaid covered services;
- Documentation that the participant and/or caregiver participated in the discharge planning process; and
- Discharge planning activities were explored at least every 60 days, or as often as changes occur.

When goals have been accomplished and/or the participant no longer requires skilled services, each discipline must promptly prepare a discharge summary to be sent to the practitioner within 30 days. The summary should document the participant's progress or lack of progress and identify the treatment goals that were met or not met. Recommendations for follow-up care should be included.

UTILIZATION REVIEW RESPONSIBILITIES OF THE HOME HEALTH AGENCY

The agency must maintain records on each participant in accordance with accepted professional standards and practices. Participant records must be complete, accurately

documented, readily accessible, and systematically organized. All entries in the participant records must be signed with the first initial, last name, and professional title of the author and completely dated with the month, day, and year. Home Health agencies must have current practitioner orders for services rendered, including orders to discontinue services if participants are discharged prior to the end of the current certification period.

Services must be provided within the requested time frames.

The Home Health agency must have written policies requiring an overall evaluation of the agency's total program at least once a year by a group of professional personnel (or a committee of this group), Home Health agency staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation must consist of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

As a part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote participant care that is appropriate, adequate, effective, and efficient. Mechanisms must be established in writing for the collection of pertinent data to assist in the evaluation.

At least quarterly, the appropriate health professionals, representing at least the scope of the program, must review a sample of both active and closed medical records to determine whether established policies are followed in furnishing services directly or under contract. There must be a continuing review of the medical records for each 60-day period that a participant receives Home Health services to determine the adequacy of the plan of care and the appropriateness of the continuation of care.

UTILIZATION REVIEW RESPONSIBILITIES OF DMAS

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes a review of the utilization of the services rendered by providers to participants. Desk and on-site reviews of each Medicaid participating Home Health provider will be made periodically, and may be unannounced. The utilization review will include a professional review of the services provided by the Home Health provider with respect to:

- The care being provided to the participants;
- The adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each participant;
- The necessity and desirability of the continued participation in Home Health services by the participant;

- The feasibility of meeting the participant's health needs in alternate care arrangements; and

- The verification of the existence of all documentation required by Medicaid to indicate that reimbursement coincides with services provided.

Other visits may be made to follow-up on deficiencies or problems, to investigate complaints, and to provide technical assistance. A plan of correction may be requested based on the findings of the visit. All utilization reviews will be followed-up with a written report to the Home Health agency outlining any areas out of compliance with DMAS regulations and policies. Services not found to be appropriate or not specifically documented in the participant's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. In addition, no reimbursement will be allowed if documentation does not reflect that services provided met program criteria.

PARTICIPANT RIGHTS

The participant has the right to confidentiality of the clinical records maintained by the Home Health agency. The agency must advise the participant of the agency's policies and procedures regarding the disclosure of clinical records.

Before the care is initiated, the Home Health agency must inform the participant, orally and in writing, of the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the Home Health agency; the charges for services that will not be covered by Medicare; and the charges that the participant may have to pay.

The participant has the right to be advised orally and in writing of any changes in the information regarding participant's rights as they occur. The Home Health agency must advise the participant of these changes as soon as possible, but no later than 30 working days from the date that the agency becomes aware of a change. The participant has the right to be advised of the availability of the toll-free complaint line established by the Department of Health, Division of Licensure and Certification. The telephone number is 1-800-955-1819. When the agency accepts the participant for treatment or care, the agency must advise the participant in writing of the telephone number and that the purpose of the hotline is to receive complaints or questions about local Home Health agencies.